DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/28/2009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G111 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 000 | INITIAL COMMENTS W 000 The facility has a system in place that A recertification survey was conducted from July 13, 2009 through July 16, 2009. The survey was notifies the individuals initiated using the fundamental survey process. A families and legal random sample of three clients was selected from a population of five female clients with various quardians for their levels of mental retardation and disabilities. medical conditions, the The findings of the survey was based on risks and benefits of their observations at the group home and two day medications; however, the programs, interviews with clients and staff, and the review of clinical and administrative records nurse failed to complete including incident reports. the consent forms. on W 124 483.420(a)(2) PROTECTION OF CLIENTS $\mathbf{W}_{7-14-09}$, he was in-serviced RIGHTS by the DON in the agency The facility must ensure the rights of all clients. notification protocol. Therefore the facility must inform each client. parent (if the client is a minor), or legal guardian, Refer to attachment #1 of the client's medical condition, developmental in the future, the nursing and behavioral status, attendant risks of management will ensure that treatment, and of the right to refuse treatment. consents are obtained, and approved prior to sedation. This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to establish a system that would ensure clients were informed of their risks and benefits of their medication, for one of the three THE DISTRICT OF COLUMBIA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

The facility failed to obtain consents prior to the use of sedation for medical appointments and/or to notify the Client #2's guardian of the risk and

clients included in the sample. (Client #2)

The findings include:

benefits of treatments.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing fromes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/28/2009 **CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G111 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION Ð **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 124 Continued From page 1 W 124 The facility has a Review of Client #2's physician orders on July 15, 2009, at 2:54 PM revealed the following orders for system in place that sedations: notifies the individuals families and legal - On June 24, 2009, Client #2 received Ativan 5 quardians for their mg prior to dental appointments; medical conditions, the - On November 11, 2008, Client #2 received risks and benefits of their Ativan 5 mg one hour prior to a dental medications; however, the appointment; and nurse failed to complete the consent forms. on 7-14-09 - On December 2, 2008, Client #2 received Ativan 7-14-09, he was in-serviced 5 mg prior to a dental appointments. by the DON in the agency During the entrance conference on July 13, 2009, notification protocol. at 4:45 PM, the Qualified Mental Retardation Refer to attachment #1 Professional (QMRP) indicated that Client #2 had in the future, the nursing a court appointed medical guardian. management will ensure that On July 14, 2009, at 10:00 AM, further review of consents are obtained, and Client #2's record failed to provide evidence that approved prior to sedation. written informed consent had been obtained for the use of the sedative medications. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using the medications, or her right to refuse treatment had been explained to the client and/or legal sanction representative. W 140 | 483.420(b)(1)(i) CLIENT FINANCES W 140 The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on

behalf of clients.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDIN		(X3) DATE SURVEY COMPLETED	
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-	PROVIDER OR SUPPLIER F WASHINGTON			1;	REET ADDRESS, CITY, STATE, ZIP CODE 326 45TH PLACE, NE VASHINGTON, DC 20019		
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	facility failed to ensi implemented to mai of clients personal facilients included in the #3) The finding includes 1. Interview with the Professional (QMRF financial records on approximately 3:30 fassisted Client #1 w Continued interview revealed that the client's according to the client's according with drawn to pure At the time of the surprovide evidence that withdrawals/expending personal account. 2. Interview with the facility's financial recording account. 2. Interview with the facility's financial recording account. 2. Interview with the facility's financial recording account. 2. Interview with the client #3 withdrawals/expending account. 3:30 Facility's financial recording account #3 withdrawals #3:30 Facility's financial recording account #3 withdrawn for the client's record reveal withdrawn from the c	are a system had been intain a complete accounting unds, for two of the three ine sample. (Clients #1 and estandation P) and review of the facility's July 15, 2009, at PM revealed that the facility ith maintaining her finances, and record review at 4:00 PM ent received Supplemental EI) in the amount of \$70.00 at of \$200.00 was withdrawn bunt on December 12, 2008. MRP indicated that the money rchase Client #1's clothing.	W 1	140	The receipts for the mon from client #1's account purchase her clothing of the located. The receipt turned to the office by house manager; the money redeposited to client #Refer to attachment #2 In the future, the facing ensure that financial refiled in the finance bothe receipts are availated request. The money was spent on client #3's vacation. To cost of total expenditure was shared among the individuals at 1326-45th Place. In the future the faciliating will ensure that the receipts are available upon request. Refer to attachment #3	t to ould not s were the was 1's acco lity wil ecords ok, and ble upon	unt. 8-05-09 1
	27, 2009. Interview with the QI money was withdraw	MRP indicated that the n for vacation expenditures.					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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W 140 W 156	provide evidence the Client #3's personal	urvey, the facility failed to at justified the withdrawal from	w ·		It is the policy o provider that all		
	The results of all invito the administrator	restigations must be reported or designated representative n accordance with State law lays of the incident.			investigations of incidents of unkno origin are complet within five workin day; however the IM failed to implemen		
	Based on interview a failed to ensure requ reviewed by the adm	not met as evidenced by: and record review, the facility lired investigations were ninistrator within five working three clients included in the			the policy. The IMC was traine the Program Direct the incident repor policy. Refer to attachment #4	or on	7-18-09
	The finding includes	:			In the future, the will ensure that a		
	Professional (QMRP incidents reports and reports on July 13, 2 revealed an incident incident dated May 2	valified Mental Retardation and review of the facility's corresponding investigative one beginning at 5:45 PM, involving Client #1. The 5, 2009 revealed that staff on Client #1's right leg.			incidents are inve and submitted on a manner.	stigated	
	revealed that the Inci Coordinator (IMC) co The administrator sig results on June 5, 20 There was no eviden investigation were re- within five working da	ompleted the investigation. Ined off on the investigative 09 (eleven days later). ce that the results of the viewed by the administrator	W 18	89			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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W 189	The facility must proinitial and continuing employee to perfore efficiently, and compare the standard on observation of the facility of the facility. (LPN #1) The finding include: Cross Refer to W 45 provide effective, efforthe prevention are communicable disease facility. (LPN #1) 483.430(e)(4) STAF Staff must be able to techniques necessal program plans for earesponsible.	ovide each employee with a training that enables the make or her duties effectively, petently. In not met as evidenced by: on and interview, the facility chemployee with continuing control that enables the make or her duties effectively, petently for one of one staff in the facility failed to ficient, and competent training and control of infection and asses for one of one staff in the facility failed to ficient, and competent training and control of infection and asses for one of one staff in the facility failed to ficient, and competent training and control of infection and asses for one of one staff in the facility failed to facility failed to ficient, and competent training and control of infection and asses for one of one staff in the facility failed to ficient for whom they are		All nurses were in-serving the DON on Refer to attachment#5 In the future, the factorising management will ensure that the infectorist control is maintained all the time during the medication administration all staff were trained the dietitian and the restaff on 6-26/09, but training was ineffective staff were retrained or Refer to attachment #6 In the future, the factorism anagement will ensure the staff offer client diet as prescribed by the dietitian.	ility ion ill ion. by iursing ihe ive. ility that #2's	7-29-09	
	Based on observation verification, the facility received their prescriptors.	not met as evidenced by: n, staff interview, and record ty failed to ensure that client's ibed diets as ordered, for one cluded in the sample. (Client					
1	_	ensure staff demonstrated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU			(X3) DATE SURVEY COMPLETED		
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W 194	competency in implorder.	ementing Client #1s diet	W	194	the dietitian and the nu staff on 6-26/09, but th	rsing ne	
	observed as a large staff was observed vanilla or chocolate Client #2's physician revealed a diet orde cholesterol diet. During the environm 2009 at approximate	4:50 PM, Client #1 was a framed women. At 5:20 PM, offering Client #2 a choice of pudding (regular). Review of a orders dated July 2009, or of 1500 low fat, low mental inspection on July 15, ely 11:00 AM, revealed that of fat free snacks in the			training was ineffective Staff were retrained on Refer to attachment # 6 In the future, the facil management will ensure t the staff offer client # diet as prescribed by th dietitian.	lity that ‡2's	7-16-09
W 255	There was no evide implemented Client 483.440(f)(1)(i) PROCHANGE	nce that the facility #3's diet as ordered. PGRAM MONITORING &	W 2	255			
İ	least by the qualified professional and rev but not limited to situ	rised as necessary, including, lations in which the client has ted an objective or objectives					
ĺ	Based on observation review, the facility's in Professional (QMRP) that Individual Programmeviewed and revised successfully complete.	not met as evidenced by: on, interview and record Qualified Mental Retardation b) failed to provide evidence am Plans (IPP)s were d once the client had ted an objective, for two of uded in the sample. (Clients			Client #1 and #2's IPPs and goals were revised by the Qmrp on		7-16-09

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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W 255	Continued From pa	-	W 2	55				
	The findings includ	e:		İ			1	
	The QMRP faile once she met the e	ed to revise Client #1's IPP stabilished criteria.			Client #1's objective self feed was revised		7-16-09	
	was observed feed snack. At 7:00 AM feeding herself indeplate, plate guard a with the Qualified M Professional (QMR approximately 10:0 client requires assist Client #1's IPP date reviewed on July 15 had a program objewill independently fe 80% of the trials for with 100% staff sup of the QMRP quarte 2009, and May 2009 PM indicated that the established criteria. At the time of the surevise Client #1's professional the established criteria. At the time of the surevise Client #1's professional the established criteria.	P) on July 14, 2009, at 0 AM indicated sometimes the stance. ed November 10, 2008, was 5, 2009, at 9:15 AM. The client ective which stated, "[the client] eed herself during meals daily, three consecutive months ervision". Record verification erly reviews dated February 9, on July 15, 2009, at 3:45 ne client achieved the since May 2009. Urvey, the QMRP failed to orgam objective once she met			The criteria was revised from 80% independence, an staff were in-service the revised goals as Refer to attachment # In the future, the Qm will ensure that the program objectives ar revised once client # establishes the criteria content to the Qmrp from 80% hover hand to 100% hand hand on In the future the Qmrp ensure that the object is revised once Client establishes the criteria criteria content to the qmrp ensure that the object is revised once Client establishes the criteria criter	to d the d on well. 6 crp e 1 cria. to wash ised and over will ive #1	7-16-09	
	the trials for three co of the QMRP quarte 2009, and May 2009	istance from staff on 80% of onsecutive months". Review rly reviews dated February 9, revealed the client required istance 99.98% of the trials.						
	_	1		- 1			1	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	 -		(X3) DATE SURVEY COMPLETED	
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W 261	There was no evidenthe program (wash c. Review of Client 2009, revealed a program and over hause the swabs to make trials for three coffine QMRP quarter 2009, and May 2009, and May 2009, and May 2009, and over hand associated the program (wash 2. Review of Client 22, 2009, on July 16 a program objective assistance, "[the clienthe QMRP quarterly 2008, March 2009, a client was a least 93]	ence that the QMRP revised upper body). It #1's IPP dated November 11, rogram objective which stated, and assistance, [the client]" assage her gums daily 80% of consecutive months". Reviewerly reviews dated February 9, revealed the client required sistance 82.42% of the trials. Ince that the QMRP revised upper body). It #2's IPP dated September 5, 2009, at 9:30 AM, revealed which stated, given physical ent]" will wash her hands 80% insecutive months". Review of reviews dated December and June 2009, revealed the 19% independently on all trials.	W 26	Client #1's objective to massage her gums was refrom 80% hand over hand on Refer to attachment #9 In the future, the Qmrp will ensure that client #1's objective is revised once she establishes the criteria. Client #2 objective to wash her hands was revised from 80% to 100% physical assistance by the Qmrp on In the future, the Qmrp will ensure that client #2 objective is revised once she established.	l to	7-16-09	
	constituted committee of members of facility guardians, clients (a persons who have el contemporary practic	signate and use a specially see or committees consisting by staff, parents, legal s appropriate), qualified ither experience or training in ces to change inappropriate persons with no ownership or the facility.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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W 261	This STANDARD is Based on interview Rights Committee (failed to ensure that controlling interest is participated on the	and the review of the Human HRC) minutes, the facility to persons with no ownership or in the facility consistently committee, for one of the ed in the sample. (Client #2)	W 26	1			
	During the entrance at 4:45 PM, the QM required sedation properties appointed medical gobysician orders on verified that sedation to be administered properties at the control of the cont	e conference on July 13, 2009, RP indicated that Client #2 rior to dental appointments. It d that Client #2 had a court guardian. Review of Client #2's July 15, 2009, at 2:54 PM in (Ativan 5 mg) was ordered prior to dental appointments 24, 2009, November 11, 2008		It is the policy of this provi	ler to have a		
W 263	meeting minutes wa 2009, at 9:48 PM. A dated July 13, 2009, dental appointment 2009, was reviewed review of the correspattached to the minutes facility's HRC commownership or control This was acknowled the QMRP, July 18,	in Rights Committee (HRC) is conducted on July 16, according to the HRC minutes. Client #2's sedation for a scheduled for the June 24, and approved. Further conding signature sheet ites failed to evidence that the ittee included persons with no ling interest in the facility. ged through interview with 2009 at 11:00 AM.	W 263	person with no ownership of interest to participate in the Committee; however, the si was out of town during the HRC meeting. In the future, the provider withere is always a member wor controlling interest to par Human Rights committee.	Human Rights tting member month of July vill ensure that ith no ownership	7-31-09	
	are conducted only v	ld insure that these programs with the written informed parents (if the client is a					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUIL			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G111	B. Wil	NG		07/	16/2009	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	This STANDARD is Based on interview facility's specially-consure that restrict after written consent of the three clients is #2) The findings included The facility failed to use of sedation for to notify the Client #0 of the risk and beneated the risk and risk	rdian. s not met as evidenced by: and record review, the constituted committee failed to ve programs were used only its had been obtained, for one included in the sample. (Client c: obtain consents prior to the medical appointments and/or 2's court appointed guardian iffits of treatments. s physician orders on July 14, vealed the following orders for Client #2 received Ativan 5 opointments; 2009, Client #2 received a dental appointment; and	W	263	This provider has a system in protifies the individuals families guardians for their medical concrisks and benefits of their medical however, the facility nurse has follow the notification protocol he was inserviced by the DON In the future, the facility will enconsents are obtained prior to as for medical procedures.	and legal ditions, the cations; failed to l. on	7-24-09	
	5 mg prior to a dental During the entrance at 4:45 PM, the Qua Professional (QMRF a court appointed mo On July 14, 2009, at Client #2's record fai	conference on July 13, 2009, lified Mental Retardation ') indicated that Client #2 had			·			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ĺ	PROVIDER OR SUPPLIER F WASHINGTON			1326	ADDRESS, CITY, STATE, ZIP CODI 45TH PLACE, NE SHINGTON, DC 20019		
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W 325	provide evidence the in using the medical treatment had been legal sanction represented 482.460(a)(3)(iii) Plant the facility must proceed to the facility must proceed to the facility must proceed to the facility must proceed to the facility must proceed to the facility must proceed to the facility must proceed to the facility's nursing laboratory testing as primary care physicial charts included in the facility's nursing laboratory testing as primary care physicial charts included in the facility's nursing laboratory testing as primary care physicial charts included in the facility's nursing laboratory testing as primary care physicial charts included in the facility's nursing laboratory testing as primary care physicial charts included in the facility of the facility of the facility of the facility of the medical amylase. Record very evidence of a lipid larview of the medical amylase study dated thowever there were laboratory study available to the facility of the facility	tive medication. urvey, the facility failed to pat the potential risks involved tions, or her right to refuse explained to the client and/or sentative. HYSICIAN SERVICES ovide or obtain annual physical ch client that at a minimum eening laboratory termined necessary by the staff failed to provide routine adtermined necessary by the ian (PCP), for one of the three he sample. (Client #1) servealed a physician order for my study and bi-annual serum erification revealed no aboratory study. Further all record revealed a serum if November 5, 2008. In o additional amylase	w a	The howe the P compute la level in the to ma	facility nursing staff complies ever, client #1's labs was done CP who ordered, and drawn bolete the lab order. The PCP diabs in May 2009 due to normal efuture, the nursing staff will anitain annual Amylase level in the lab annual Amylase level.	on 11-08 by lood to d not repeat l Amylase obtain an orde	
	PCP's office and she	e determines when and which					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		09G111	B. WING		07/1	6/2009	
	PROVIDER OR SUPPLIER F WASHINGTON			REET ADDRESS, CITY, STATE, ZI 1326 45TH PLACE, NE WASHINGTON, DC 20019		. <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 325	Continued From pa	ige 11	W 325		· · · · · · · · · · · · · · · · · · ·		
W 331		should be conducted. NG SERVICES	W 331	l l			
		ovide clients with nursing nce with their needs.					
i	Based on observati verification, the faci establish systems to monitoring and iden	s not met as evidenced by: on, interview and record lity's nursing services failed to o provide health care stify services in accordance for three of three clients in the , #2 and #3)				·	
	15, 2009 at 10:02 A Physician (PCP) pro 2009. The PCP pro centimeters round a on upper right and le start Ketoconazole caffected area. On J progress notes state the April 21, 2009, Fordered the client to cream 2% externally area, twice a day for on May 19, 2009 for spoke with the nurse Client #3 never start cream 2%".	#3's medical record on July M revealed a Primary Care ogress note dated April 21, ogress note stated, "2 grythematous scaly patch, two eff leg". The PCP order to cream 2%, one application to une 9, 2009, another PCP ed the same information as PCP progress note. The PCP start Miconazole Nitrate via 30 grams, apply to affected six weeks. Patient was seen a same condition. The PCP et and it was confirmed that the disconazole Nitrate		The nursing staff was not #3 was prescribed Micon on her routine PCP visit of the PCP did not send the or medical consult on that Client #3 was not seen by This was the documentat on the 6-9-09 consult. The Miconazole Nitrate of 6-09-09, and treatment we 6-20-09. The PA was information in the ferrors.	nazole Nitrate cream on 4-21-09 because prescription at date. y her PCP on 5-19-09 ion error by the PA cream was prescribed vas initiated on		
!	Licensed Practical N	egistered Nurse (RN) and lurse Coordinator (LPNC) on roximately 12:20 PM ad not received the		·			

	AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:		A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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W 331	aforementioned ord Further review of Cl July 16, 2009, rever	→	W	331			
	staff failed to provid determined necessar	V325. The facility's nursing e routine laboratory testing as ary by the primary care rone of three clients included ont #1)			Refer to W 325 P11		7-27-09
	staff failed to ensure administration assure	V368. The facility's nursing to that their system for drug red that all drugs are at error for one of three clients ple. (Client #1)			Refer to W 369 P. 14		7-27-09
	staff failed to remov	v390. The facility's nursing e from use, out dated e of three clients included in #1)			Refer to W 390 P. 15		7-27-09
W 369	staff failed to provide prevention and cont three clients include	V455. The facility's nursing e an active program for the rol of infection for one of d in the sample. (Client #2) & ADMINISTRATION	W3	69	Refer to W 455 P.17		7-27-09
	that all drugs, includ	administration must assure ing those that are re administered without error.					
	Based on observation	not met as evidenced by: on, interview and record led to assure that all drugs compliance with the					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUIL	LDING		(X3) DATE SURVEY COMPLETED	
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	physician's orders, included in the sam The finding includes On July 13, 2009, a observed to experie to three (3) seconds room table, having approximately 8:28 (LPN #1) administer 1000 mg, Keppra 50 mouth. Interview wit was prescribed the for seizure manager Registered Nurse S approximately 8:50 aforementioned meadministered between Review of Client #1' Record's (MAR's) da 2009 at approximate #1 was to be admini Depakote 1000 mg at 7:00 PM. 483.460(m)(2)(i) DR The facility must remaining the facility must remained the facili	for one of three clients ple. (Client # 1) i: t 7:31 PM, Client #1 was ince a seizure lasting two (2) is while sitting at the dining dinner. On July 13, 2009, at PM, Licensed Practical Nurse red to Client #1, Depakote DO mg and Dilantin 300 mg by th LPN #1 revealed Client #1 aforementioned medications ment. Interview with the upervisor on July 13, 2009 at PM, revealed the dications were to be en 7:00 PM and 8:00 PM. Is Medication Administration ated July 2009, on July 13, ely 8:29 PM, revealed Client stered Dilantin 300mg, and Keppra 500mg by mouth UG LABELING not met as evidenced by: n, the facility failed to remove ed medications, for one of d in the sample. (Client # 1)	W 3	medications are administer The LPN was inserviced by compliance with the agenc medication administration In the future the nursing mensure that the medications as prescribed. Refer to attachment #11	ed as prescribed. y the DON to ensu y policy of . anagement will	7-27-09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
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W 390	2009, at approximal Practical Nurse #1 (instill two (2) drops right and left ear as Physician (PCP). Review of the label on July 13, 2009, at revealed the Baby Capril 1, 2009". In an interview with approximately 8:28 If Client #1's Baby Oil	administration on July 13, tely 8:25 PM, the Licensed (LPN #1) was observed to of Baby Oil into Client #1's ordered by the Primary Care on the bottle of the Baby Oil approximately 8:27 PM Oil was to be "discarded after LPN #1 on July 13, 2009, at PM, it was acknowledged had expired on April 1, 2009.	W 390	It is the nursing policy of the the medications are removed cabinet upon expiration. The failed to remove the expired from the cabinet. The nurse was inserviced by the disposal of medications nursing best practices. Refer to attachment # 11. In the future the nursing material ensure that all of the outdates are removed from the cabinets.	d from the e facility nurse I medication y the DON on according to nagement will ed medications	7-27-09	
	use out dated medic 483.470(g)(2) SPAC The facility must furn and teach clients to use choices about the use hearing and other countries and other devices identerdisciplinary team. This STANDARD is Based on observation verification, the facility repair, adaptive feedithree clients included.	aish, maintain in good repair, use and to make informed to of dentures, eyeglasses, immunications aids, braces, entified by the as needed by the client. Inot met as evidenced by: In, staff interview and record of failed to maintain in good and equipment for one of the in the sample (Client #2):	W 436	The built up handle coated sporeplaced on A new shower chair was order		7-16-09 8-04-09	
	three clients included in the sample (Client #2); and failed to ensure that the adaptive shower chair was safe for clients use, for four of the five clients residing in the facility. (Clients #1, #2, #4, and #5)			,			
		i					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC- (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D RE	(X5) COMPLETION DATE
W 436	On July 13, 2009, at observed eating dinhandle coated spoowas worn and the sispoon. Review of Client #2's (IHP) dated August 12:10 PM revealed the adaptive equipment coated teaspoon. In Mental Retardation In 16, 2009, at 11:30 A had some new adap During the exit confers 12:30 PM, the QMRI revealed the new addiction #2.	to ensure that Client #2 was reding equipment. 1 7:25 PM, Client #3 was ner using an adaptive built up n. The coating on the spoon liver was exposed on the 1 S Individual Habilitation Plan 25, 2009, on July 14, 2009, at that the client's mealtime consisted of built up handle terview with the Qualified Professional (QMRP) on July M indicated that the client tive feeding equipment. 1 P and House Manager aptive feeding equipment for	W4		The built up handle coated spoon was replaced on In the future the management will ensthe mealtime adaptive equipment is a and in good condition.	sure that	7-16-09
	that the adaptive feet for Client #2. 2. The facility failed the shower chair was sate the five clients residing #2, #4, and #5) On July 13, 2009, at and #5 were observed environmental inspect 10:00 AM, a shower chathroom shower. The	to ensure that the adaptive to ensure that the adaptive fe for clients use, for four of og in the facility. (Clients #1, #2, #4, d in wheelchairs. During the tion on July 16, 2009, at chair was observed in the ne shower chair did not have to the chair. Interview with			A new shower chair was ordered on In the future the facility management that all adaptive equipment are in goo condition.		

09G111 B. WING	07/46/2000		
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE WASHINGTON, DC 20019	07/16/2009 DE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLETION		
W 436 Continued From page 16 the House Manager (HM) on July 16, 2009, at 10:05 AM indicated that she would retrieve the shower chair seatbelt. At 10:20 AM, the HM could not find or located the shower chair seatbelt. W 455 W 455			
There must be an active program for the prevention, control, and investigation of infection and communicable diseases.			
This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for two of three clients in the sample. (Clients #2 and #3)			
1. During medication administration observation on July 13, 2009, at approximately 7:55 PM, the Licensed Practical Nurse #1 (LPN #1) was observed to wash her hand prior to administrating medications. However LPN #1 touched the combination lock to open the medication Administration Records (MAR's) and than touched the rim of the medication cup as she administered Client #2's medication. In an interview with LPN #1 it was acknowledged that after washing her hands she touched the combination lock to open the medication door, touched the MAR's and than touched the rim of the medication cup when administering Client.	7-27-09 d and inet		
the medication cup when administering Client #2's medication.			

W 455 Continued From page 17 There is no evidence that the facility's nursing	INCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X2) MULTIPLE (X2) MULTIPLE (X3) MULTIPLE (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X4) MULTIPLE (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (X4) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/	CONSTRUCTION (X3) DATE SURVEY COMPLETED	
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 455 Continued From page 17 There is no evidence that the facility's nursing	GTON 1326	ADDRESS, CITY, STATE, ZIP CODE 45TH PLACE, NE	
There is no evidence that the facility's nursing	DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLETIO CROSS-REFERENCED TO THE APPROPRIATE DATE	N
staff provided an active program for the prevention and control of infection. 2. The facility failed to ensure infection control practices were implemented prior to a meal being served, for two of the three clients included in the sample. (Client #2 and #3) a. On July 13, 2009, at approximately 4:50 PM, Client #3 was observed folding towels. At 5:20 PM, staff was observed providing the client with an afternoon snack. Seconds later the client was observed eating her snack without washing her hands. The direct care staff did not encourage the client to wash her hands or wash the client's hand. At no time did staff encourage them to wash their hands before sitting at the table to eat. There was no evidence that proper infection control procedures were implemented during the dinner preparation. b. On July 13, 2009, at 4:50 PM, until 5:15 PM, Client #1 was observed using a hand manipulator. At 5:20 PM, staff was observed providing Client #1 with an afternoon snack. Seconds later the client was observed eating her snack without washing her hands. At no time did staff encourage them to wash their hands before sitting at the table to eat. There was no evidence that proper infection control procedures were implemented during the dinner preparation.	no evidence that the facility's nursing vided an active program for the on and control of infection. acility failed to ensure infection control were implemented prior to a meal being or two of the three clients included in the (Client #2 and #3) by 13, 2009, at approximately 4:50 PM, was observed putting puzzle numbers At 5:15 PM, Client #3 was observed the client with an afternoon snack. It later the client was observed eating her hout washing her hands. The direct idid not encourage the client to wash her wash the client's hand. at did staff encourage them to wash their fore sitting at the table to eat. There was not extend using a hand for. At 5:20 PM, staff was observed Client #1 with an afternoon snack. attent the client was observed eating her nout washing her hands. Reference that proper infection control is staff encourage them to wash their fore sitting at the table to eat. There was not extend the client was observed eating her nout washing her hands. Reference that proper infection control is staff encourage them to wash their fore sitting at the table to eat. There idence that proper infection control is were implemented during the dinner washing her hands.	fection control. Il staff were trained on infection control by e Qmrp on efer to attachment # 13 the future the facility will ensure that staff uplement proper infection control procedures uring mealtime preparation, and mealtime.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **B. WING** HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1 000 INITIAL COMMENTS 1000 A licensure survey was conducted from July 13, 2009 through July 16, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of five female residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports. 1 082 3503.10 BEDROOMS AND BATHROOMS 1082 Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure all bathrooms were equipped with a cup dispenser to accommodate the needs of The cup dispenser was replaced on 7-16-09 residents, for four of the five residents residing in the facility. (Residents #1, #2, #3, and #5) In the future, the facility management will ensure that all bathrooms are equipped with The finding includes: a cup dispenser to accommodate the needs of the residents. An environmental inspection was conducted on July 16, 2009, at approximately 10:00 AM revealed that the handicapped bathroom located on the first floor did not have a cup dispenser. The House Supervisor confirmed the findings. Healin Regulation Administration all thector

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PRINTED: 07/28/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1189 Continued From page 2 1189 ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to maintain each resident's funds disbursed, for two of the three residents included in the sample. (Residents #1 and #3) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's The receipts for the money withdrawn from financial records on July 15, 2009 at client #1's account to purchase her clothing approximately 3:30 PM revealed that the facility assisted Resident #1 with maintaining her ould not be located. The receipts were turned finances. Continued interview and record review to the office by the house manager; however, at 4:00 PM revealed that the resident received the money was redeposited to client #1's Supplemental Security Income (SSI) in the 8-5-09 account on amount of \$70.00 per month. Further review of Refer to attachment #14. the resident's record revealed a total of \$200.00 was withdrawn from the resident's account on In the future, the facility will ensure that December 12, 2008. copies of the financial record are filed in the finance book, and that they are available upon Further interview with the QMRP indicated that request. the money was withdrawn to purchase Resident #1's clothing. At the time of the survey, the facility failed to provide evidence that justified the withdrawals/expenditures from Resident #1's personal account. The money was spent on client #3's vacation. 2. Interview with the QMRP and review of the The cost of the total expenditures was shared facility's financial records on July 15, 2009, at

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approximately 3:30 PM revealed that the facility

finances. Continued interview and record review at 4:00 PM revealed that the resident received

amount of \$70.00 monthly. Further review of the resident's record revealed a total of \$253.46 was

assisted Resident #3 with maintaining her

Supplemental Security Income (SSI) in the

request.

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Refer to attachment #3

among the individuals residing at 1326-45th place.

In the future, the facility will ensure that the

receipts for the expenditures are available upon

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no evidence of current health certificates on file

for two of the eleven consultants (Occupational

Interview with the Qualified Mental Retardation Professional (QMRP) July 15, 2009 at 3:30 PM confirmed the missing health certificates were not

Therapist and Speech Pathologist)

In the future, the provider will ensure that

the consultant's records are up to date and

available upon request.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** 1206 Continued From page 4 1206 available. 1225 3510.5(b) STAFF TRAINING 1225 Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death): This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to ensure training was provided to each staff in the area of Human Development, for one (1) of fourteen (14) training records. The finding includes: All staff were trained on Human Development on 7-16-09 Review of the training records presented on July Refer to attachment #15 14, 2009 at approximately 4:00 PM, revealed that 7-16-09 the staff did not have training in Human In the future the management will ensure that Development. staff receive the training in human The Qualified Mental Retardation Professional development. confirmed the findings. 1 226 3510.5(c) STAFF TRAINING 1226 Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; Refer to W455 P.18 7-27-09 This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, Health Regulation Administration

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING **B. WING** HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1226 Continued From page 5 J 226 for one of one nursing staff. The finding includes: During medication administration observation on July 13, 2009, at approximately 7:55 PM the Licensed Practical Nurse #1 (LPN #1) was observed to wash her hands prior to administering medications. However LPN #1 Refer to W 455 P.18 touched the combination lock to open the 7-27-09 medication door, touched the Medication Refer to W 455 P.18 7-27-09 Administration Records (MAR's) and than touched the rim of the medication cup when administering Resident #2's medication. In an interview with LPN #1 it was acknowledged that after washing her hands she touched the combination lock to open the medication door. touched the MAR's and than touched the rim of the medication cup as she administered Resident #2's medication. There is no evidence that the facility's nursing staff had effective training on infection control. 1 229 3510.5(f) STAFF TRAINING 1229 Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited

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technologies;

to, behavior management, sexuality, nutrition, recreation, total communications, and assistive

Based on observation, staff interview, and record verification, the facility failed to ensure that client's received their prescribed diets as ordered

This Statute is not met as evidenced by:

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On July 13, 2009 at 4:50 PM, Client #1 was observed as a large framed women. At 5:20 PM, staff was observed offering Client #2 a choice of vanilla or chocolate pudding (regular). Review of Client #2's physician orders dated July 2009, revealed a diet order of 1500 low fat, low cholesterol diet.

During the environmental inspection on July 15, 2009 at approximately 11:00 AM revealed that there was a variety of fat free snack in the pantry.

There was no evidence that the facility implemented Client #3's diet as ordered.

1 274 3513.1(e) ADMINISTRATIVE RECORDS

Each GHMRP shall maintain for each authorized agency 's inspection, at any time, the following administrative records:

(e) Signed agreements or contracts for professional services:

This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of contracts for four of the eleven consultants reviewed. (Occupational Therapist. Social Worker, Speech Pathologist and Psychiatrist)

1274

Social Worker, Speech Pathologist, and the Social Worker are currently on file. Refer to attachment # 16 In the future, the provider will ensure that the consultant records are updated, and available upon request.

The contracts for the Occupational Therapist,

Refer to W 194 P. 6 of 18

Refer to W 194 P. 6 of 18

7-31-09

7-16-09

7-16-09

Health Regulation Administration

Health Regulation Administration

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER: A. BUILDII			(X3) DATE SURVEY COMPLETED		
HFD03-0142				B. WING		07/1	6/2009	
,			,		Y, STATE, ZIP CODE			
WA			WASHING	8 45TH PLACE, NE BHINGTON, DC 20019				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPR DEFICIENCY)	IOUD BE COMPLETE		
1 274	Continued From page	ge 7		1274	The contract for the Occupation	al Theranic		
j 1					Psychiatrist, Speech Pathologist	•	1.	
	The finding includes	S .		'	Worker are currently on file.	, and book	7-31-09	
! 	Review of the consu	iltants personnel rec	orde		In the future, the provider will e	nsure that		
	presented on July 14	4, 2009 at approxima	ately 2:00		all of the consultant records are	updated, ar	nd	
ĺ	PM, revealed that th	e GHMRP failed to	ensure		available upon request.			
	the Occupational The Speech Pathological Pat	ierapist, the Social V hist and the Psychial	Vorker, triet had			,] 	
j	signed contracts wh	o provided onsite an	d					
I	ongoing services to	the residents.						
<u> </u> 	The Qualified Mental Retardation Professional confirmed the findings.		sional					
l 424	3521.5(a) HABILITA	TION AND TRAININ	ig	1 424			,	
į	Each GHMRP shall resident 's program or when the client:	make modifications t at least every six (6)	to the months					
1	(a) Has successfully objectives identified i Plan;	completed an object in the Individual Hab	tive or ilitation					
	This Statute is not meased on staff intervolutional Retrospection (QMRP) failed to review Program Plan (IPP) concessfully completed IPP, for two of the sample. (Resident's	iew and record revie ardation Professional iew and revise the In once the resident had ed an objective ident of three residents in the	il idividual d tified in					
٦	The finding includes:							
1	The QMRP failed once she met the estate	to revise Resident # ablished criteria.	1's IPP		Refer to W. 255 P. 7 of 18		7-16-09	
V	a. On July 13, 2009, vas observed feeding	at 5:38 PM, direct ca Resident #1 her aft	are staff ernoon	i			ļ	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE OMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY: 1 424 Continued From page 8 1424 Refer to W. 255 P. 7 of 18 7-16-09 snack. At 7:00 AM, Resident #1 was observed feeding herself independently using a scoop plate, plate guard and regular spoon. Interview with the Qualified Mental Retardation Professional (QMRP) on July 14, 2009, at approximately 10:00 AM indicated sometimes the resident requires assistance. Review of Resident #1's IPP dated November 10. 2008, was reviewed on July 15, 2009, at 9:15 AM. Refer to W. 255 P. 7 of 18 7-16-09 The resident had a program objective which stated, "[the resident] will independently feed herself during meals daily, 80% of the trials for three consecutive months with 100% staff supervision". Record verification of the OMRP quarterly reviews dated February 2009, and May 2009, on July 15, 2009, at 3:45 PM indicated that the resident achieved the established criteria since May 2009. At the time of the survey, the QMRP failed to revise Resident #1's program objective once she met the established criteria. b. Review of Resident #1's IPP dated November 11, 2009, revealed a program objective which stated, "[the resident]" will wash her upper body with hand over hand assistance from staff on Refer to W. 255 P. 7 of 18 7-16-09 80% of the trials for three consecutive months". Review of the QMRP quarterly reviews dated February 2009, and May 2009, revealed the resident required hand over hand assistance 99.98% of the trials. There was no evidence that the QMRP revised the resident's program (wash upper body). c. Review of Resident #1's IPP dated November 11, 2009, revealed a program objective which Refer to W. 255 P. 7 of 18 7-16-09 stated, "given hand over hand assistance, [the

PRINTED: 07/28/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) ! 424 Continued From page 9 1424 Refer to W. 255 P. 7 of 18 7-16-09 resident]" use the swabs to massage her gums daily 80% of the trials for three consecutive months". Review of the QMRP quarterly reviews dated February 2009, and May 2009, revealed the resident required hand over hand assistance 82.42% of the trials. There was no evidence that the QMRP revised Resident #1's program (wash upper body). 2. Review of Resident #2's IPP dated September 22, 2009, on July 16, 2009, at 9:30 AM, revealed a program objective which stated. 7-16-09 Refer to W. 255 P. 7 of 18 given physical assistance, "[the resident]" will wash her hands 80% of trials for three consecutive months". Review of the QMRP quarterly reviews dated December 2008, March 2009, and June 2009, revealed the resident was a least 93% independently on all trials. There was no evidence that the QMRP revised Resident #2's program (wash her hands). 1 430 3521.7(a) HABILITATION AND TRAINING 1430 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners,

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use of adaptive equipment, and use of

This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to maintain in good repair, adaptive feeding equipment for one of the three residents included in the sample (Resident #2); and failed to ensure that the adaptive shower

appropriate utensils);

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PRINTED: 07/28/2009 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1430 i Continued From page 10 1430 chair was safe for resident use, for four of the five residents residing in the facility. (Residents #1, #2, #4, and #5) The findings include: 1. The facility failed to ensure that Resident #2 was provided adaptive feeding equipment. On July 13, 2009, at 7:25 PM, Resident #3 was observed eating dinner using an adaptive built up handle coated spoon. The coating on the spoon was worn and the silver was exposed on the spoon. Review of Resident #2's Individual Habilitation Plan (IHP) dated August 25, 2009, on July 14. 2009, at 12:10 PM revealed that the resident's mealtime adaptive equipment consisted of built up handle coated teaspoon. Interview with the Qualified Mental Retardation Professional (QMRP) on July 16, 2009, at 11:30 AM indicated that the resident had some new adaptive feeding Refer to W 436 P.16 7-16-09 equipment. During the exit conference on July 16, 2009, at 12:30 PM, the QMRP and House Manager revealed the new adaptive feeding equipment for Resident #2. Refer to W 436 P.16 7-16-09 There was no evidence that the facility ensured that the adaptive feeding equipment was available for Resident #2.

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2. The facility failed to ensure that the adaptive shower chair was safe for residents' use, for four of the five resident's residing in the facility.

On July 13, 2009, at 4:45 PM, Resident's #1, #2. #4, and #5 were observed in wheelchairs. During the environmental inspection on July 16, 2009, at

(Resident's #1, #2, #4, and #5)

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Refer to W 436 P.16

8-5-09

PRINTED: 07/28/2009 FORM APPROVED **Health Regulation Administration** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) 1430 Continued From page 11 1430 10:00 AM, a shower chair was observed in the Refer to W 436 P.16 8-5-09 bathroom shower. The shower chair did not have a seat belt attached to the chair. Interview with the House Manager (HM) on July 16, 2009, at 10:05 AM indicated that she would retrieve the Refer to W 390 PP 14, 15 7-27-09 shower chair seatbelt. At 10:20 AM, the HM could not find or located the shower chair seatbelt. 1484 3522.11 MEDICATIONS 1484 Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a

worn, illegible, or missing label.

This Statute is not met as evidenced by: Based on observation, interview and label verification the Group Home for the Mentally Retarded (GHMRP) failed to promptly destroy prescribed medication that has reached the expiration date, for one of three residents in the sample. (Resident #1)

The finding includes:

During medication administration on July 13, 2009, at approximately 8:25 PM, Licensed Practical Nurse #1 (LPN) was observed to instill two (2) drops of Baby Oil into Resident #1's right and left ear as ordered by the Primary Care Physician (PCP).

Review of the label on the bottle of Baby Oil on July 13, 2009 at approximately 8:27 PM revealed the Baby Oil was to be "discarded after April 1, 2009".

In an interview with LPN #1 on July 13, 2009, at approximately 8:28 PM it was acknowledged

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FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0142 07/16/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1326 45TH PLACE, NE R C M OF WASHINGTON WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1484 | Continued From page 12 1484 Refer to W 390 PP 14, 15 7-27-09 Resident #1's Baby Oil had expired on April 1, 2009. There was no evidence the GHMRP promptly destroy prescribed medication that had reached the expiration date. 1500 3523.1 RESIDENT'S RIGHTS 1500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. , This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137 (Rights of Mentally Retarded Citizens), this chapter, and other applicable District and Federal Laws, for one of the three residents included in the sample. (Resident #2) The findings include: 1. The facility failed to obtain consents prior to Refer to W 124 P.2 7-27-09 the use of sedation for medical appointments and/or to notify the Resident #2's guardian of the risk and benefits of treatments. Review of Resident #2's physician orders on July 15, 2009, at 2:54 PM revealed the following Refer to W 390 PP 14, 15 7-27-09 orders for sedations:

5 mg prior to dental appointments;

- On June 24, 2009, Resident #2 received Ativan

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Refer to W 390 PP 14, 15

7-27-09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0142 NAME OF PROVIDER OR SUPPLIER STREET AG		IDENTIFICATION NU				(X3) DATE SURVEY COMPLETED	
		DESS CITY	STATE ZID CODE	1 Un	16/2009		
D C M OF WARMINGTON 1326 45T		DDRESS, CITY, STATE, ZIP CODE TH PLACE, NE IGTON, DC 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	OULD BE	(XS) COMPLETE DATE
I 500		2008, Resident #2 r	eceived	I 500	Refer to W 390 PP 14, 15		7-27-09
	Ativan 5 mg prior to During the entrance at 4:45 PM, the Qua Professional (QMR	2008, Resident #2 re a dental appointment conference on July alified Mental Retard P) indicated that Res ed medical guardian	nts. 13, 2009, ation sident #2		Refer to W 390 PP 14, 15		7-27-09
·	Resident #2's recor that written informe for the use of the se At the time of the su provide evidence th in using the medica	t 10:00 AM, further red failed to provide even deconsent had been edative medications. Invey, the facility failed at the potential risks tions, or her right to a explained to the response explained.	ed to involved		Refer to W 390 PP 14, 15 Refer to W		7-27-09
	2. Based on intervient Human Rights Comfacility failed to ensuownership or controconsistently particip	ew and the review of imittee (HRC) minute ure that persons with illing interest in the fa ated on the committe idents included in the	es, the no ncility ee, for		refer to W 261 P.9 of 18		7-31-09
	The finding includes	i :					
	at 4:45 PM, the QMI required sedation programmer was further indicated court appointed med Resident #2's physical resident physical resid	conference on July RP indicated that Re for to dental appoint that Resident #2 hadical guardian. Reviecian orders on July 1 that sedation (Ativan	ments. It ad a w of 5, 2009.				

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-0142 07/16/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1326 45TH PLACE, NE R C M OF WASHINGTON **WASHINGTON, DC 20019** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 1500 1500 Continued From page 14 was ordered and administered prior to dental appointments scheduled for June 24, 2009. November 11, 2008 and December 2, 2008. Review of the Human Rights Committee (HRC) meeting minutes was conducted on July 16, 2009, at 9:48 PM. According to the HRC minutes -31-09 dated July 13, 2009. Resident #2's sedation for a Refer to W 261 P 9 of 18 dental appointment scheduled for the June 24, 2009, was reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility. This was acknowledged through interview with the QMRP, July 16, 2009 at 11:00 AM.

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